

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
BUREAU OF HEALTH SYSTEMS
INFORMAL DEFICIENCY RESOLUTION REQUEST – LEVEL 2

Send this form (typed/printed) with documentation to:

MDCH, BHS, Operations, Enforcement Unit, IDR Requests, P.O. Box 30664, Lansing, MI 48909.

The PoC should be submitted to the Licensing Officer that signed the Statement of Deficiencies (CMS-2567L).

This IDR is to be reviewed by:

☐ **Bureau of Health Systems Staff**

OR

☐ **MPRO (Facility agrees to pay fee for service).**

Facility:		Survey Exit Date:	
1. Tag No(s):			
2. Citation fact(s)/statement(s) requested for review:			
3. Factual evidence that you believe refutes the above fact(s)/statement(s): (pages should be numbered; for example, 1 of 20, 2 of 20, etc.)			
4. Explain if the above evidence was not available at time of survey:			
Facility Contact Person:		Date:	Phone #:
REVIEWER RESPONSE – LEVEL 2			
Deficiency is:	<input type="checkbox"/> Supported in full	<input type="checkbox"/> Amended	<input type="checkbox"/> Deleted
Reason:			
Reviewer Signature:		Code/s: 1 2 3 4 5 6 7 8 9 10 11	
By:	Title:	Date:	